10-minute consultation

Hyperhidrosis

Jo Piercy

Useful reading

The Whitely Clinic. Sweating.co.uk: the latest in treatment of excessive sweating. www.sweating.co.uk (Suitable for patients.)

Bandolier. Botulinum toxin for hyperhidrosis. www.jr2.ox.ac.uk/bandolier/booth/neurol/hyperhid.html

A 26 year old woman presents with excessive sweating, which she says embarrasses her socially and at work. Sometimes her hands literally drip with sweat, making work involving writing difficult. Concerned to conceal her excessive axillary sweating, she is self conscious and particular about her clothing. She asks what help you can give her.

What issues you should cover

Location—Explore and identify the exact locations of the sweating. Possibilities include excessive facial flushing and sweating and axillary, palmar, groin, and plantar hyperhidrosis.

Severity—How disabling is the problem? Explore the effects on her emotional wellbeing and daily social life.

Exclude physiological and psychological causes—Consider other causes, such as hypoglycaemia or hyperthyroidism, although usually these will be obvious. Might there be an anxiety state?

Explanation and advice—Reassure her that sweating is a normal phenomenon. Explain that the evaporation of water from the skin takes heat away from the body and is essential for temperature control and that sweating is controlled by the sympathetic nervous system. It is important that she drink plenty of fluids and consider boosting salt intake, as fluid loss can be substantial.

What you should do

- Be supportive and acknowledge that this is a distressing condition.
- Discuss treatment options with her. First line treatments are topical antiperspirants such as aluminium chloride hexahydrate 20% solution. Drug treatment can be of benefit. A low dose of a ß blocker such as propranolol may help. Another possibility is propantheline (Pro-Banthine) in a starting dose of 15 mg three times daily (its side effects are antimuscarinic and include dry mouth and constipation).
- Discuss what options might be available from specialists. If anxiety is felt to be the predominant cause, consider referring her to mental health services for cognitive behaviour therapy or biofeedback. Dermatologists may recommend iontophoresis. This involves a small electrical bath in which the hands and feet can be soaked for a number of minutes a week. It works by stopping the sweat glands from producing sweat. Patients can often try out this treatment under hospital supervision to see if it works. They can then buy their own baths for about £250 ($475; €360). This is a very effective treatment for palmar and plantar hyperhidrosis but is ineffective for axillary symptoms.
- Botulinum toxin injections seem to be effective, especially for axillary symptoms. The treatment lasts 6-9 months and then needs repeating. It works by inhibiting the release of acetylcholine at the neuromuscular junction and therefore reduces muscle tone and production of sweat. With palmar injections a long term consideration would be the effect on muscle tone.
- For very resistant and distressing cases, where all other treatments fail, a surgical procedure called thoracoscopic sympathectomy is available. This is where the sympathetic nerve is cut. In the United Kingdom it is performed mostly by vascular surgeons and is available mainly in the private sector, although some regional centres offer this procedure through the NHS for appropriate cases. The main side effect, which is reasonably common and unwelcome, is compensatory sweating in other areas.

I thank Alison Bedlow, consultant dermatologist at Warwick Hospital, for her helpful correspondence.

Endpiece

At Talbott-Marsh

"I have a lot of debt, if that's what you mean. My partnership dissolved, so I had to set up my own office. But I'm getting back on track. I cover four different hospitals. No one has ever complained about my work . . ."

"The *work* is the last thing to suffer," an intense older man across the room burst in, unable to keep quiet any longer. He wore half-moon glasses over which he peered at the newcomer. He had a thick Southern accent. "The order in which you dee-stroy your life," he said, holding out his hand and pulling down fingers, "is first family, then you screw your partners, then you screw up your finances, then your health goes. Hell, your job performance is the last thing to go."

The burly Californian stirred in his chair. He was embarrassed. If this had been a staff meeting at his own hospital, he would have told this hick to go to hell.

"I should know, son," the man went on, whipping off his glasses, his tone softening, but not much. "I was confronted only when I passed out in the OR and fell face forward into the abdomen I had just opened. In the two years preceding that, I'd lost everything: my family, my friends, my money. I protected my job till the very end, and even when they sent me here, I still didn't think I really had a problem, came here to be ee-valuated . . ."

From Abraham Verghese's *The Tennis Partner*, a story of medical addiction (Vintage, 1999)

This is part of a series of occasional articles on common problems in primary care

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